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	17E071	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 3RD ST PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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sample included 13 residents. Based on observation, record review, and interview the facility failed to notify the physician and legal representative for Resident #27 and #28 regarding resident to resident altercations, and Resident #32's physician regarding lack of bowel movements for several days.

Findings included:

- Resident #28's admission (MDS) Minimum Data Set assessment, dated 3/16/15, indicated the resident had a (BIMS) Brief Interview of Mental Status score 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had no behaviors, and required extensive staff assistance with (ADLs) Activities of Daily Living.

The 3/16/15 care plan indicated the resident used a wheelchair for mobility and propelled him/herself around the building. The care plan instructed staff to reorient and supervise the resident as needed, and to report to the nurse when the resident becomes anxious or had increased negative behaviors.

The 4/23/15 facility report indicated Resident #27 hit Resident #28 on top of his/her head and Resident #28 hit the resident back on his/her hand. The report indicated there had been two incidents of physical aggression between the two residents and if the behavior continued it would be addressed with the physician. The report indicated the staff had not notified Resident #28's family or physician of the incident.

The 4/24/15 facility report indicated Resident #27 was pushing Resident #28 in his/her wheelchair down the hallway, and when arrived at the dining

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room, Resident #27 hit the Resident #28 on his/her head, with his/her hand. The report indicated the staff had not notified the family and physician of the incident.

The 5/11/15 facility report indicated on 5/9/15 at 7:52 PM Resident #27 was standing by the facility cafe and Resident #28 wheeled by him/her, in a wheelchair, stating multiple times"I want to go home" . The note indicated Resident #27 raised his/her voice, told Resident #28 to "shut up", and proceeded to slap the resident, multiple times, across the face. The note indicated the Resident #28 covered his/her head, cried and screamed "he/she is gonna kill me". The note indicated the staff had not notified the family and the physician of the incident.

The 5/23/15 at 7:20 PM nurse's note indicated Resident #27 pushed Resident #28 in his/her wheelchair in the hall. The note indicated an aide found the Resident #28 crying and in a panic, and asked the resident what was wrong. The note indicated the Resident #28 told the aide that Resident #27 had hit him/her on the head, with his/her fist, and it hurt.

The 5/23/15 facility report indicated Resident #27 had been pushing Resident #28, in his/her wheelchair, and an aide found the Resident #28, by himself/herself, crying and in a panic. The report indicated the resident told the aide Resident #27 had hit him/her, with his/her fist, in the head, and it hurt. The report indicated the staff had not notified the resident's family or physician of the incident.

On 12/3/15 at 10:30 AM, observation revealed Resident #28 propelled him/herself in a wheelchair into the commons area, backed into

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F 157	Continued From page 3 Resident #27, who was seated on a couch, with his/her wheelchair, and Resident #27 gently pushed Resident #28's wheelchair away from him/her. On 12/3/15 at 2:29 PM, Administrative Nurse A stated he/she would have expected staff to notify the resident's legal representative and physician after each incident. The facility's 7/20/15 Notification of Changes policy stated the facility should keep families informed of resident's medical/mental status, appointments, incidents or other pertinent information. The policy stated staff will notify by telephone, or in person when applicable, the resident, their legal representatives and any interested family members. Staff will document who was notified and what time they were notified in a progress note in the resident's chart. The facility failed to notify the legal representative and the physician regarding the above incidents, involving severely cognitively impaired Resident #28. - Resident #27's (POS) Physician Order Sheet, dated 11/30/15, indicated the resident had diagnoses of anxiety (a fear or nervousness about what might happen), and hypertension (high blood pressure), dementia (deterioration of intellectual faculties such as memory, concentration, and judgement, resulting from an organic disease or disorder). The admission (MDS) Minimum Data Set assessment, dated 4/20/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 0 which indicated severely impaired	F 157		

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F 157	Continued From page 4	F 157		

cognition. The assessment further revealed the resident required limited assistance of 1 staff member for bed mobility, dressing and personal hygiene. The assessment further revealed the resident wandered 4 to 6 days a week and rejected care 1 to 3 days a week.

The 1/27/15 Behavior (CAA) Care Area Assessment indicated the resident wandered almost continuously, checked all the doors, and talked about wanting to leave the facility. The CAA further stated the resident wandered out of other resident's room.

The quarterly MDS, dated 10/18/15, indicated the resident had a BIMS score of 3 which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff member for bed mobility, transfers, dressing, toileting and personal hygiene. The assessment further revealed the resident wandered daily and had no behaviors.

The 4/23/15 care plan revealed the resident had a diagnosis of dementia, and may ask the same questions several times, but is easily redirected. The care plan lacked direction to staff for interventions to assist with the resident's behaviors.

The 4/23/15 at 2:36 PM, nurse's note stated the resident hit Resident #28 on top of his/her head. The note further stated the staff separated the residents and the resident was counseled about striking others. Review of the medical record revealed the physician, and family were not notified of the incident.

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F 157	Continued From page 5 The 4/24/15 at 2:36 PM, nurse's note stated the resident was pushing Resident #28 in his/her wheelchair into the dining room. The note further stated the resident hit Resident #28 and staff separated the two residents. The note stated the staff counseled the resident about striking others. Review of the medical record revealed the physician and family were not notified of the incident. The 4/24/15 facility report concluded no injuries sustained by either resident involved and the staff will monitor the resident's behaviors and contact the physician should the behaviors reoccur. The 5/9/15 at 7:52 PM, nurse's note stated the resident was standing by the dining room when Resident #28 wheeled by in his/her wheelchair. Resident #28 voiced, multiple times "I want to go home" . Resident #27 told Resident #28 to "shut up" and proceeded to slap Resident #28 multiple times when he/she did not stop saying he/she wanted to go home. The nurse's note stated Resident #28 covered his/her head and cried, "he/she is going to kill me". The staff separated the two resident's and Resident #28 was assessed and no injury was found. The note stated Resident #27 was told to keep his/her distance from Resident #28 and staff to him/her that it was not nice to hit people. Review of the medical record revealed the physician and family were not notified of the incident. The 5/9/15 facility report concluded no injuries sustained by either resident involved and directed the staff to keep the two residents separated. The 5/23/15 at 7:16 PM, nurse's note stated the staff found the resident pushing Resident #28, who was crying and in a panic. The note stated,	F 157		

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the staff asked Resident #28 what was wrong. Resident #28 stated Resident #27 punched him/her in the head. Resident #28 stated his/her head hurt from where he/she was hit. The hospital staff assessed the resident and no injury was found. The note further stated the two resident's have been encouraged to keep their distance from one another. Review of the medical record revealed the physician and family were not notified of the incident.

The 5/23/15 facility report concluded the incident was unwitnessed and no injuries found on Resident #28. The report stated both resident's have a diagnosis of dementia and unsure as to which resident investigated the incident.

The 5/24/15 at 7:54 PM, nurse's note stated staff separated the resident from Resident #28 after the resident hit Resident #28 on the face and told him/her to "shut up". Review of the medical record revealed the physician and family were not notified of the incident and no incident report was completed.

On 12/1/15 at 1:30 PM, observation revealed the resident ambulating down the hallway asking staff, "what can I do?" Further observation revealed the resident was smiling and pleasant.

On 12/3/15 at 12:41 PM, Licensed Nurse B stated the resident has had problems with Resident #28 and had hit the resident but stated the resident had not done anything like that recently.

On 12/3/15 at 12:56 PM, Nurse Aide K stated the resident has not had any inappropriate behavior on his/her shift and would get the nurse if the

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F 157	Continued From page 7 resident was not easily redirected. On 12/3/15 at 1:45 PM, Administrative Nurse A stated the physician and family should be notified for any resident to resident altercations. The 8/23/06 facility's Notification of Change Policy was to keep families informed of resident's medical and mental status incidents or other pertinent information. The policy further stated the resident's physician would be notified of all non emergent notification questions or concerns of a resident's medical status by communication sheet faxed to the clinic. The facility failed to notify Resident #27's family and physician that he/she had been involved in multiple resident to resident altercations. - Resident #32's medical record revealed the facility admitted the resident on 8/11/15. The (POS) physician's order sheet, dated 9/18/15, revealed the resident had a diagnosis of constipation (bowel movements that are infrequent or hard to pass). The admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident was always continent of bowel. The quarterly MDS, dated 11/17/15, indicated the	F 157		

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F 157	Continued From page 8 resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident was occasionally incontinent of bowel. The 8/13/15 care plan stated the resident did not have constipation and directed the staff to toilet the resident per the toileting schedule. The care plan lacked direction for the staff regarding bowel management. The 8/11/15 physician standing orders directed the staff to administer the following: (MOM) Milk of Magnesium, (a laxative for constipation) 30 (cc) cubic centimeters, by mouth, with breakfast, if no bowel movement for 3 days. Dulcolax Suppository, (a laxative for constipation inserted into the rectum) rectally, once at bedtime, if the resident has not had a bowel movement for 4 days. The order further directed the staff to notify the physician if no bowel movement for 5 days. The October Bowel Movement Record revealed no documentation the resident had a bowel movement from 10/1/15 to 10/15/15 (15 consecutive days). The November Bowel movement Record revealed no documentation the resident had a bowel movement from 11/3/15 to 11/17/15 (15 consecutive days) and no bowel movement from 11/18/15 to 11/27/15 (10 consecutive days). The October and November (MAR) Medication Administration Record revealed the staff had not	F 157		

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F 157	Continued From page 9 provided physician ordered interventions to the resident for the lack of bowel elimination, as outlined in the physician standing orders. On 12/2/15 at 4:37 PM, observation revealed the resident lying in bed on his/her right side, Nurse Aide G performed personal hygiene on the resident, replaced the disposable incontinent pad, put a pillow between his/her knees, and covered the resident. On 12/2/15 at 4:37 PM, Nurse Aide D stated staff chart bowel movements in the computer system. Nurse Aide D stated, if the resident doesn't have a bowel movement for 3 days, the staff notify the nurse. On 12/2/15 at 2:47 PM, Licensed Nurse B stated the computer system and staff tell him/her when a resident has not had a bowel movement after 3 days and the nurse initiates the standing orders. On 12/3/14 at 1:45 PM, Administrative Nurse A stated the staff should notify the physician when the resident had not had a bowel movement for over 5 days. The Facility's undated Notification to the Physician Policy directed staff to fax all non emergent notifications, questions or concerns of a resident's medical status to the medical clinic. The facility failed to seek physician involvement in a timely manner, concerning Resident #32's lack of bowel movement.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 10 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to report altercations involving	F 225		

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F 225	Continued From page 11 Resident #27 and #28 on several different occasions to the state agency . Findings included: - Resident #28's admission (MDS) Minimum Data Set assessment, dated 3/16/15, indicated the resident had a (BIMS) Brief Interview of Mental Status score 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had no behaviors, and required extensive staff assistance with (ADLs) Activities of Daily Living. The 3/16/15 behavior (CAA) Care Area Assessment indicated the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion), family only wants him/her to take Xanax (an antianxiety medication) as needed. The assessment indicated the resident wandered and asked to go home, and calls staff some profanity names but is usually easily redirected. The 3/16/15 care plan indicated the resident used a wheelchair for mobility and propelled him/herself around the building. The care plan instructed staff to reorient and supervise the resident as needed, and to report to the nurse when the resident becomes anxious or had increased negative behaviors. The 4/23/15 facility report indicated Resident #27 hit Resident #28 on top of his/her head and Resident #28 hit the resident back on his/her hand. The report indicated there had been two incidents of physical aggression between the two residents and if the behavior continued it would be addressed with the physician. Review of the medical record revealed the incident was not	F 225		

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F 225	Continued From page 12 called to the state agency. The 4/24/15 facility report indicated Resident #27 was pushing Resident #28 in his/her wheelchair, down the hallway, when they arrived at the dining room, hit the resident on his/her head with his/her hand. Review of the medical record revealed the incident was not called to the state agency. The 5/11/15 facility report indicated on 5/9/15 at 7:52 PM Resident #27 was standing by the facility cafe and Resident #28 wheeled by him/her in a wheelchair stated, multiple times "I want to go home". The note indicated Resident #27 raised his/her voice, told Resident #28 to "shut up", and proceeded to slap the resident multiple times across the face. The note indicated Resident #28 covered his/her head, cried and screamed, "he/she is going to kill me". Review of the medical record revealed the incident was not called to the state agency. The 5/23/15 at 7:20 PM nurse's note indicated Resident #27 pushed Resident #28 in his/her wheelchair in the hall. The note indicated an aide found Resident #28 crying and in a panic, and asked the resident what was wrong. The note indicated Resident #28 told the aide Resident #27 had hit him/her on the head with his/her fist, and it hurt. Review of the medical record revealed the incident was not called to the state agency. The 5/23/15 facility report indicated Resident #27 had been pushing Resident #28, in his/her wheelchair, and an aide found Resident #28 by himself/herself crying and in a panic. The report indicated the resident told the aide Resident #27 had hit him/her, with his/her fist, in the head, and it hurt. Review of the medical record revealed the incident was not called to the state agency.	F 225		

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F 225	Continued From page 13 On 12/3/15 at 10:30 AM, observation revealed Resident #28 propelled him/herself in a wheelchair into the commons area, backed into Resident #27, who was seated on a couch, and Resident #27 gently pushed Resident #28's wheel chair away from him/her. On 12/3/15 at 7:53 AM, Administrative Nurse A verified the resident to resident altercations were not called to the state agency. The facility's 11/17/2009 Abuse and Neglect policy stated all residents/patients have the right to be free from abuse, neglect, and exploitation. The policy stated all alleged violations involving mistreatment, neglect, or abuse, including all injuries of unknown source and misappropriation of resident property will be reported to the state survey and certification agency immediately (as soon as possible, but ought not to exceed 24 hours after discovery of the incident as per KDOA(Kansas Department On Aging) clarification) and to all other agencies as required by the risk manager or director of nursing. The facility failed to report altercations involving Resident #28, who was hit by another resident multiple times and on several different occasions to the state agency. - Resident #27's (POS) Physician Order Sheet, dated 11/30/15, indicated the resident had diagnoses of anxiety (a fear or nervousness about what might happen), and hypertension (high blood pressure), dementia (deterioration of intellectual faculties such as memory,	F 225		

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concentration, and judgement, resulting from an organic disease or disorder).

The admission (MDS) Minimum Data Set assessment, dated 4/20/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 0 which indicated severely impaired cognition. The assessment further revealed the resident required limited assistance of 1 staff member for bed mobility, dressing and personal hygiene. The assessment further revealed the resident wandered 4 to 6 days a week and rejected care 1 to 3 days a week.

The 1/27/15 Behavior (CAA) Care Area Assessment indicated the resident wandered almost continuously, checked all the doors, and talked about wanting to leave the facility. The CAA further stated the resident wandered out of other resident's room.

The quarterly MDS, dated 10/18/15, indicated the resident had a BIMS score of 3 which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff member for bed mobility, transfers, dressing, toileting and personal hygiene. The assessment further revealed the resident wandered daily and had no behaviors.

The 4/23/15 care plan revealed the resident had a diagnosis of dementia, and may ask the same questions several times, but is easily redirected. The care plan lacked direction to staff for interventions to assist with the resident's behaviors.

The 4/23/15 at 2:36 PM, nurse's note stated the resident hit Resident #28 on top of his/her head. The note further stated the staff separated the

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F 225	Continued From page 15 residents and the resident was counseled about striking others. Review of the medical record revealed the physician, and family were not notified of the incident. The 4/24/15 at 2:36 PM, nurse's note stated the resident was pushing Resident #28 in his/her wheelchair into the dining room. The note further stated the resident hit Resident #28 and staff separated the two residents. The note stated the staff counseled the resident about striking others. Review of the medical record revealed the physician and family were not notified of the incident. The 4/24/15 facility report concluded no injuries sustained by either resident involved and the staff will monitor the resident's behaviors and contact the physician should the behaviors reoccur. The 5/9/15 at 7:52 PM, nurse's note stated the resident was standing by the dining room when Resident #28 wheeled by in his/her wheelchair. Resident #28 voiced, multiple times, "I want to go home". Resident #27 told Resident #28 to "shut up" and proceeded to slap Resident #28 multiple times when he/she did not stop saying he/she wanted to go home. The nurse's note stated Resident #28 covered his/her head and cried, "he/she is going to kill me". The staff separated the two resident's and Resident #28 was assessed and no injury was found. The note stated Resident #27 was told to keep his/her distance from Resident #28 and staff to him/her that it was not nice to hit people. Review of the medical record revealed the physician and family were not notified of the incident.	F 225		

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The 5/9/15 facility report concluded no injuries sustained by either resident involved and directed the staff to keep the two residents separated.

The 5/23/15 at 7:16 PM, nurse's note stated the staff found the resident pushing Resident #28, who was crying and in a panic. The note stated, the staff asked Resident #28 what was wrong. Resident #28 stated Resident #27 punched him/her in the head. Resident #28 stated his/her head hurt from where he/she was hit. The hospital staff assessed the resident and no injury was found. The note further stated the two resident's have been encouraged to keep their distance from one another. Review of the medical record revealed the incident was not called to the state agency.

The 5/23/15 facility report concluded the incident was unwitnessed and no injuries found on Resident #28. The report stated both resident's have a diagnosis of dementia and unsure as to which resident investigated the incident.

The 5/24/15 at 7:54 PM, nurse's note stated staff separated the resident from Resident #28 after the resident hit Resident #28 on the face and told him/her to "shut up". Review of the medical record revealed the incident was not called to the state agency.

On 12/1/15 at 1:30 PM, observation revealed the resident ambulating down the hallway asking staff, "what can I do?" Further observation revealed the resident was smiling and pleasant.

On 12/3/15 at 7:53 AM, Administrative Nurse A verified the resident to resident altercations were

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F 225	Continued From page 17 not called to the state agency. The 11/17/09 facility's Abuse and Neglect Policy stated the policy of the facility was all residents have the right to be free from abuse, neglect, and exploitation and will be reported to the state survey and certification agency as soon as possible. The facility failed to report altercations involving Resident #27, who hit another resident multiple times and on several different occasions to the state agency.	F 225		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents of which 5 were reviewed for activities. Based on observation, record review and interview, the facility failed to provide an ongoing program for activities to meet the interests and the physical, mental, and psychosocial well-being and ensure residents were aware of activities, and offered activity attendance for 5 of the 5 residents reviewed for activities (#27, #32, #14, #2, #28) Findings included: - Resident #27's admission (MDS) Minimum Data Set assessment, dated 1/27/15, indicated	F 248		

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F 248	Continued From page 18 books, newspapers, group activities and music are somewhat important to the resident. The MDS further indicated that animals are very important to the resident. Resident #27's quarterly MDS, dated 10/18/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3 which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff member for bed mobility, transfers, dressing, toileting, and personal hygiene. The admission 1/27/15 Activity (CAA) Care Area Assessment did not trigger. The 10/19/15 care plan stated the resident wandered around the facility all day and loves to help. The care plan stated the resident will ask many times a day what he/she can do to "help". The care plan further directed the staff to invite and take the resident to all activities 4-5 times a week. The September 2015 Activity Participation log revealed the resident attended 5 activities during the month. The 10/20/15 untimed quarterly activity review stated the resident will sit during an activity for 5 minutes and likes to walk a lot. The October 2015 Activity Participation log revealed the resident attended 9 activities during the month.	F 248		

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F 248	Continued From page 19 The November 2015 Activity Participation log revealed the resident attended 7 activities during the month. On 12/1/15 at 1:30 PM, observation revealed the resident ambulating up and down the halls asking, "What can I do?" On 12/1/15 at 3:00 PM, observation revealed no residents at the 3:00 PM scheduled activity finish scrabble tile tree ornaments. On 12/1/15 at 3:30 PM, observation revealed the resident ambulating up and down the halls asking, "What can I do?" On 12/2/15 at 10:30 AM, observation revealed the resident ambulating around the dining room and he/she asked staff what he/she could do. Further observation revealed nail care and group exercises in the dining room. The resident was told he/she could have nail care and staff would get him/her when it was his/her turn but the resident did not receive nail care. On 12/2/15 at 3:13 PM, Activity Staff C stated he/she doesn't have many activities for residents with dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) On 12/2/15 at 1:45 PM, Administrative Nurse A verified the facility should have more activities for residents with dementia.	F 248		

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The 7/20/15 facility Activity Policy stated the facility will ensure an ongoing program of activities designed to accommodate the individual resident's interests to help his/her physical, mental, and physical well-being according to his/her comprehensive assessment.

The facility failed to offer, remind, and assist Resident #27, to attend activities, and provide activities in accordance with the resident's comprehensive assessment.

- Resident #32's quarterly (MDS) Minimum Data Set assessment, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment indicated the resident required extensive assistance of 2 staff members for bed mobility, transfers, and ambulation on and off the unit, dressing, toileting and personal hygiene.

The admission MDS dated, 8/11/15, indicated it was very important to attend his/her favorite activities, church, and pets and was somewhat important to attend group activities.

The 8/11/15 (CAA) Care Area Assessment for Activities stated the resident does not attend many activities.

The 11/19/15 care plan indicated the resident would attempt to attend 1 to 2 activities of choice a week and would continue to visit with his/her spouse and other family members. The care plan

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F 248	Continued From page 21 further stated the resident enjoyed sports on television and enjoyed watching the news before bed. The 8/11/15 activity review indicated the resident would like to attend church, devotions and communion. The September 2015 Activity participation log revealed the resident did not attend any activities but received foot care 3 times that month. The October 2015 Activity participation log revealed the resident did not attend any activities but had 2 times of individual activities. The 11/13/15 quarterly review revealed the resident enjoyed foot care, attended bingo a couple of times, and was very personable. The November 2015 Activity participation log revealed the resident attended 1 activity during the month. On 12/3/15 at 1:30 PM, observation revealed the resident lying in bed with his/her eyes closed. On 12/2/15 at 8:00 AM, Nurse Aide D stated recently the resident has not left his/her room for activities because he/she was too weak. Nurse Aide D stated the resident's spouse visits the resident daily. On 12/2/15 at 3:13 PM, Activity Staff C stated he/she had not done any 1:1 or any type of	F 248		

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F 248	Continued From page 22 activity with the resident since he/she stopped coming out of his/her room. On 12/3/15 at 1:45 PM, Administrative Nurse A stated staff should do more 1:1 activities with the resident. Administrative Nurse A further stated the resident's spouse and family visit with the resident daily. The 7/20/15 facility Activity Policy stated the facility will ensure an ongoing program of activities designed to accommodate the individual resident's interests to help his/her physical, mental, and physical well-being according to his/her comprehensive assessment. The facility failed to offer, remind, and assist Resident #27, to attend activities, and provide activities in accordance with the resident's comprehensive assessment. - Resident #2's admission (MDS) Minimum Data Set assessment, dated 4/14/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score 14, which indicated the resident cognitively intact. The MDS indicated it was very important for the resident to listen to music, do favorite activities, go outside to get fresh air when the weather was good, and to participate in religious services or practices. The quarterly MDS, dated 10/18/15, indicated the resident had a BIMS of 15, which indicated the resident cognitively intact. The MDS indicated the	F 248		

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F 248	Continued From page 23 resident required limited staff assistance with walking in room, corridor, and extensive staff assistance with locomotion on the unit. The 10/21/15 care plan instructed staff to assist the resident as needed. The care plan instructed the activity director to invite and encourage the resident to attend activities the resident liked. The activity attendance sheet revealed the following: In September the resident did not attend any type of activity on 18 days during the month. In October the resident did not attend an type of activity on 17 days during the month. On 12/1/15 at 8:50 AM, observation revealed the resident did not attend or participate in an activity, during the first two days of the onsite survey. On 12/2/15 at 8:45 AM, Nurse Aide I stated when the activity director is not in the facility, staff are to volunteer to do activities, if they have time, or volunteers from outside the facility will provide some activities. On 12/2/15 at 8:50 AM, observation revealed a dry erase board between the guest bathroom and the drinking fountains stated activities for the day were nail care at 9:00 AM, exercises at 10:30 AM, cotton ball game at 3:00 PM, and bible study at 6:30 PM. Further observation revealed at 9:16 AM nail care was not provided by the facility. Continued observation revealed at 10:30 AM, nail care and exercise activities started at the same time and the resident was present, but did not receive nail care.	F 248		

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F 248	Continued From page 24 On 12/2/15 at 2:44 PM, Activity Staff C stated when he/she is not in the facility, a nurse aide or volunteers from outside the facility provide the activities for the resident if he/she wants to attend. On 12/2/15 at 4:16 PM, Nurse Aide F stated the resident likes to go to devotions and likes to read books. Nurse Aide F stated the resident usually remembers times of activities and will call for assistance to activities. On 12/3/15 at 1:45 PM, Administrative Nurse A stated staff should do more 1:1 activities with the resident. Administrative Nurse A further stated the resident's spouse and family visit with the resident daily. The facility's 7/20/15 Activity Assessments policy stated the facility ensured an ongoing program of activities for the resident, designed to accommodate the individual resident's interests and help enhance her/his physical, mental and psychosocial well-being, according to his/her comprehensive assessment. The facility failed to offer, remind, and assist Resident #2, to attend activities, and provide activities in accordance with the resident's comprehensive assessment. - Resident #28's physician order sheet, dated 9/30/15, indicated the resident had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and psychosis (any major mental disorder characterized by a gross impairment in reality	F 248		

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testing), and hallucinations (sensing things while awake that appear to be real, but the mind created).

The admission (MDS) Minimum Data Set assessment, dated 3/16/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score 0. The MDS indicated the resident required extensive assistance of 2 staff for bed mobility, transfer, dressing, and toilet use, supervision with locomotion on and off unit, and used a wheelchair for mobility. The MDS indicated it was somewhat important for the resident to listen to music, to do things with groups of people, go outside to get fresh air when the weather is good, and very important to do his/her favorite activity.

The 3/16/15 care plan instructed staff to invite/encourage the resident to attend an activity, daily. The care plan instructed staff to visit 1:1 with the resident and the family visited several times weekly. Review of the care plan revealed no individualized interventions related to areas important to the resident.

The activity attendance record indicated the resident attended activities 4 times in September and did not attend any activities in October.

On 12/3/15 at 1:09 PM, Nurse Aide H stated the resident sometimes propelled him/herself to exercise but does not attend often.

On 11/30/15 and 12/1/15, observation revealed the resident did not attend or participate in an activity.

On 12/2/15 at 3:13 PM, Activity Staff C stated he/she doesn't really have any activities for dementia residents and has never thought about

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F 248	Continued From page 26 looking into the residents past occupation. On 12/3/15 at 1:45 PM, Administrative Nurse A stated staff should do more 1:1 activities with the resident. Administrative Nurse A further stated the resident's spouse and family visit with the resident daily. The facility's 7/20/15 Activity Assessments policy stated the facility ensured an ongoing program of activities for the resident, designed to accommodate the individual resident's interests and help enhance her/his physical, mental and psychosocial well-being, according to his/her comprehensive assessment. The facility failed to offer, remind, and assist Resident #28, to attend activities, and provide activities in accordance with the resident's comprehensive assessment . - Resident #14's annual (MDS) Minimum Data Set assessment, dated 10/4/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 0 which indicated severely impaired cognition. The assessment revealed the resident was dependent upon 2 staff for bed mobility, transfers, personal hygiene and bathing and 1 staff member for mobility on and off the unit, dressing and eating. The assessment further revealed it was somewhat important to the resident to listen to music, be around animals, keep up with the news, go outside, and participate in religious services. The resident's	F 248		

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F 248	Continued From page 27 family or significant other completed the identification of activity preferences for the resident. The 10/04/15 psychosocial well-being (CAA) Care Area Assessment stated the resident does attend some activities each week, does not usually participate, but does like to watch. The CAA futher stated the resident does well when family and spouse visit. The 10/14/15 care plan stated the resident would like to attend activities at least three times weekly and directed staff to invite him/her to devotions, church and reading programs. The care plan directed staff to offer to take the resident out to the courtyard on nice days and take him/her to nail care and hair care weekly. The care plan indicated the activity director will visit with the resident 1:1, 1-2 times monthly, and staff will provide 1:1 daily. The September 2015 Activity Participation log revealed the resident attended 10 activities for the month. The log had no documentation of 1:1 visits with the activity director or staff, for the month of September. The October 2015 Activity Participation log revealed the resident attended 18 activities for the month. The log had no documentation of 1:1 visits with the activity director or staff, for the month of October. The November 2015 Activity Participation log revealed the resident attended 4 activities for the month. The log had no documentation of 1:1 visits with the activity director or staff, for the month of November.	F 248		

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F 248	Continued From page 28 On 12/1/15 at 1:22 PM, observation revealed the resident resting in his/her room in bed. Further observation revealed the resident continued to rest in bed at 2:06 PM and at 3:45 PM. On 12/2/15 at 4:00 PM, observation revealed the resident resting in his/her room in bed. There was not any music playing in the room and the television was not on. Further observation revealed staff and residents decorating the Christmas tree and the resident did not attend the activity. On 12/3/15 at 9:07 AM, observation revealed the resident resting in bed, in his/her room and a devotion activity, with singing, in the dining room. On 12/2/15 at 1:00 PM, Nurse Aide D stated the resident doesn't really do much for activities, and staff do 1:1 visiting with him/her. On 12/2/15 at 3:16 PM, Activity Staff C stated the resident doesn't do much for activities, and staff brought him/her up to observe group activities sometimes. Activity Staff C further stated that he/she doesn't really do as much 1:1 with him/her as he/she should. On 12/3/15 at 11:45 AM, Administrative Nurse A verified the resident does not attend many activities and was unable to state any activities that occurred in the resident's room. Administrative Nurse A further stated the resident's spouse visits daily in the evening and his/her family attends family meals every other month. The 7/20/15 facility Activity Policy stated the facility will ensure an ongoing program of activities designed to accommodate the individual	F 248		

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F 248	Continued From page 29 resident's interests to help his/her physical, mental, and physical well-being according to his/her comprehensive assessment. The facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being for Resident #14.	F 248		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to conduct a significant change assessment for 2 of the 13 sampled residents. (#10, #32) Findings included: - Resident #10's quarterly (MDS) Minimum Data Set assessment, dated 7/12/15, indicated the resident had a (BIMS) Brief Interview for Mental	F 274		

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F 274	Continued From page 30 Status score of 7, which indicated severely impaired cognition and was independent with (ADLs) Activities of Daily Living. Resident #10's quarterly MDS, dated 10/11/15, indicated the resident had a BIMS of 8, which indicated moderately impaired cognition. The MDS indicated the resident required limited staff assistance with ADLs except, supervision with eating. The 10/14/15 care plan indicated the resident was able to transfer him/herself from his /her wheelchair to the recliner, to the toilet, and back. The care plan indicated the resident required staff assistance with ambulating, with his/her four wheeled walker. On 12/1/15 at 9:00 AM, observation revealed staff assisting the resident with a gait belt and four wheeled walker from his/her room to the dining room. On 12/2/15 at 4:16 PM, Nurse Aide F stated the resident required staff assistance with ADLs. On 12/2/15 at 2:40 PM, Nurse B stated the resident required staff assistance with ADLs. On 12/3/15 at 10:38 AM, Administrative Nurse verified the resident had changes in several areas of ADLs from 7/12/15 quarterly MDS to 10/11/15 quarterly MDS and stated there should have been a significant change MDS on 10/11/15. The Resident Assessment Instrument Manual Version 3.0 defines a significant change as a decline or improvement in a resident's status that: *Will not normally resolve itself without	F 274		

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F 274	Continued From page 31 intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for decline only) *Impacts more than 1 area of the resident's health status: and *Requires interdisciplinary review and/or revision of the care plan. The facility failed to conduct a significant change MDS to guide staff for care of Resident #10, who had a decline in ADLs. - Resident #32's admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14, which indicated intact cognition. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, dressing, toileting, personal hygiene, transfers, ambulation in room, and supervision of 1 staff member for ambulation in corridor, locomotion on and off the unit. The resident required supervision and set up assistance with eating. The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident required extensive assistance of 2 staff members for bed mobility, transfers, locomotion on and off unit, dressing, toileting, personal hygiene, and extensive assistance of one staff member for eating. The assessment further revealed the	F 274		

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F 274	Continued From page 32 resident ambulated 1 time in his/her room and no ambulation in the corridor. On 12/1/15 at 11:58 AM, observation revealed the resident lying in bed with his/her eyes closed. On 12/2/15 at 8:00 AM, observation revealed Nurse Aide F elevated the resident's head of his/her bed, asked the resident if he/she was hungry. The resident whispered "No". Nurse Aide F placed a toothette and into a glass of water to give to the resident. The resident did accept the toothette multiple times but did not want to eat or drink anything else. Continued observation revealed Nurse Aide F and Nurse Aide D put the head of the bed down and rolled the resident onto his/her left side. Nurse Aide F performed personal hygiene care on the resident and replaced the disposable incontinent chucks pad under the resident, placed a pillow between his/her legs, and covered the resident. On 12/2/15 at 4:16 PM, observation revealed Nurse Aide G and Nurse Aide D rolled the resident to his/her right side,and performed personal hygiene on the resident. Further observation revealed the resident stated he/she wanted to get up and sit on the toilet. Nurse Aide D and Nurse Aide G started to sit the resident on the edge of the bed, the resident closed his/her eyes and leaned over resting his/her head onto Nurse Aide G. Continued observation revealed Nurse Aide D left the room to get the nurse to assess the resident.	F 274		

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F 274	Continued From page 33 On 12/3/15 at 1:47 PM, observation revealed the resident lying in bed with his/her eyes closed. On 12/2/15 at 8:00 AM, Nurse Aide F stated the resident was unable to tolerate leaving his/her room due to his/her decline. On 12/2/15 at 4:16 PM, Nurse Aide G stated the resident does not eat well for staff or family and had become weak. Nurse Aide G further stated the resident does not leave his/her room anymore and was dependent upon the staff for all activities of daily living. On 12/3/15 at 1:45 PM, Administrative Nurse A stated the staff should have completed a significant change for the resident since he/she had a significant decline. The Resident Assessment Instrument Manual 3.0 defines a significant change as a decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, is not "self-limiting" (for decline only) -Impacts more than 1 area of the resident's health status: and -requires interdisciplinary review and/or revision of the care plan. The facility failed to conduct a significant change MDS for Resident #32, who had an overall decline.	F 274		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=D	Continued From page 34 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to accurately assess resident status, on the (MDS) Minimum Data Set assessment, for 2 of 13 sampled residents. (#14, #32) Findings included:	F 278		

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F 278	Continued From page 35 - Resident #32's quarterly (MDS) Minimum Data Set assessment, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident required extensive assistance of 2 staff members for bed mobility, transfers, dressing, toileting, personal hygiene and 1 staff member for eating. The assessment further revealed the resident had a weight loss and was on a physician prescribed weight loss regimen. The care plan, dated 11/19/15, stated the resident would maintain adequate nutritional status, by maintaining his/her weight within 2 pounds, and was on a pureed diet. The care plan directed the staff to give the resident power shakes, three times a day, with a packet of benecalorie (a high calorie supplement),1 time a day, for weight loss. The 11/30/15 physician's order directed staff to offer the resident vanilla yogurt with meals, and a multivitamin supplement daily. On 12/2/15 at 8:00 AM, observation revealed Nurse Aide F and Nurse Aide D raised the head of the resident's bed to assist the resident with breakfast. Further observation revealed, Nurse Aide F offered the resident yogurt, and the resident's supplement multiple times, but the resident refused. On 12/2/15 at 8:10 AM, Nurse Aide F stated the resident did not eat well and is offered a protein shake and ensure when he/she refuses meals. Nurse Aide F stated the resident has had a weight loss, and doesn't eat for staff or the resident's spouse.	F 278		

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F 278	Continued From page 36 On 12/3/15 at 1:45 PM, Administrative Nurse A stated the resident had a significant weight loss, was not on a physician planned weight loss regimen, and verified the MDS was inaccurate. The Resident Assessment Instrument, user manual version 3.0, stated the definition of a physician prescribed weight-loss regimen is a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. The physician may employ a calorie-restricted diet or other weight loss diets and exercise. This would also include planned diuresis (increased or excessive production of urine) and it is important that weight loss is intentional. The facility failed to accurately document, no planned weight loss management on the MDS, for Resident #32, who had a significant weight loss. - Resident #14's quarterly (MDS) Minimum Data Set assessment, dated 7/8/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 0 which indicated severely impaired cognition. The assessment revealed the resident was dependent upon 2 staff for bed mobility, transfers, mobility on the unit, eating, toilet use, dressing, personal hygiene, bathing, and 1 staff member for mobility off the unit. The assessment further revealed the resident walked in his/her room once or twice, during the assessment period with one staff assist, and walked in the corridor once or twice during the assessment period with 2 staff assist. Resident #14's annual MDS assessment, dated 10/4/15, indicated the resident had a BIMS score of 0 which indicated severely impaired cognition. The assessment revealed the resident was	F 278		

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F 278	Continued From page 37 dependent upon 2 staff for bed mobility, transfers, dressing, personal hygiene and bathing; and 1 staff member for mobility on and off the unit, toilet use, and eating. The assessment further revealed the resident walked in his/her room once or twice during the assessment period with one staff assist, and walked in the corridor once or twice during the assessment period with 2 staff assist. The 10/4/15 (CAA) Care Area Assessment for (ADL) Activities of Daily Living Functional/Rehabilitation Potential did not trigger. The care plan, dated 7/23/15 and 10/14/15 stated the resident was unable to ambulate related to weakness and Alzheimer's Disease. The care plan further stated the resident used a wheelchair for mobility, unable to propel himself/herself, and directed the staff to use the Hoyer Lift (a mechanical lift that allows residents to be transferred from one surface to another without the resident having to bear weight) and 2 staff assist for all transfers. On 12/2/15 at 8:57 AM, observation revealed Nurse Aide D and Nurse Aide F transferred the resident with the Hoyer lift from the wheelchair into his/her bed, provided urinary incontinence cares, and repositioned the resident. On 12/3/15 at 2:56 PM, Administrative Nurse A stated the resident had not walked in years and verified that the resident cannot and did not walk. Administrative Nurse A further verified the MDS coding was inaccurate. The (RAI) Resident Assessment Instrument, user manual version 3.0, pages G3-G6 stated the information coded on the MDS for section G is for a 7-day look back period only; to code 7 for	F 278		

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F 278	Continued From page 38 self-performance if the activity occurred fewer than three times. The RAI also stated in chapter 4, pages 2-10, CAA documentation helps to explain the basis for the care plan by showing how the interdisciplinary team determined the underlying causes, contributing factors, and risk factors that were related to the care area condition for a specific resident. The facility failed to accurately assess and code Resident #14's quarterly and annual MDS in Section G and on the annual MDS.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on	F 280		

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F 280	Continued From page 39	F 280		

observation, record review and interview, the facility failed to review and revise the care plan for 1 sampled resident for accidents. (#32)

Findings included:

- Resident #32's admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident had unsteady balance, no functional upper or lower impairment, and no falls since admission.

The 8/17/15 (CAA) Care Area Assessment for activities of daily living was not completed.

The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 staff for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident had unsteady balance, no functional upper or lower impairment, and had 2 or more falls since admission.

The 8/13/15 care plan stated the resident, a high risk for falls, had an unsteady gait, and used the call light when needing assistance. The care plan directed the staff to keep the bed in the lowest position to minimize injury should he/she fall out of bed. The updated 11/6/15 care plan directed staff to place a fall mat beside the resident's bed. The care plan lacked further intervention for staff after the resident had falls on 11/12/15, 11/18/15,

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F 280	Continued From page 40 11/24/5, 11/28/15, and 12/3/15. The 11/6/15 at 3:31 AM, nurse's note indicated the staff found the resident on his/her knees and elbows on the floor, a few feet from his/her bed. The note further indicated the resident stated he/she was trying to shut off his/her light. The note stated the staff assisted the resident to his/her feet, and then assisted him/her to the bathroom. The note further stated the resident's legs gave out while being assisted back to bed and the staff used a wheelchair to get him/her back to bed. The 11/12/15 at 6:45 PM, nurse's note stated the staff found the resident on the floor in front of his/her recliner on his/her alarm pad. The note stated the resident's alarm was not connected to the chair and stated the resident had no injury. The facility educated the staff to make sure the alarm was appropriately attached. The 11/18/15 at 1:35 AM, nurse's note stated the staff found the resident with his/her head on the floor mat and his/her legs still in the bed. The note stated the resident had two nickel size abrasions to the top and front of his/her head. The 11/18/15 fall risk assessment indicated the resident was a high risk for falls. The 11/24/15 at 3:27 PM, nurse's note stated the staff found the resident standing beside his/her bed, as the resident slowly lowered him/herself to the floor onto his/her knees. The note stated the resident had no injury. The 11/28/15 at 4:05 PM, nurse's note stated the resident leaned over the armrest of the recliner and his/her spouse could not get the resident	F 280		

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GREELEY COUNTY HOSPITAL LTCU	506 3RD ST PO BOX 338 TRIBUNE, KS 67879

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F 280	Continued From page 41 back up into the recliner. The note stated the resident's spouse assisted the resident down the footrest of the recliner and onto the floor. The 12/3/15 at 6:14 AM, nurse's note stated the staff found the resident lying on his/her right side on the floor mat beside the bed. The note stated the alarm was sounding and the resident was assisted back to bed. On 12/1/15 at 11:58 AM, observation revealed the resident lying in his/her bed with eyes closed. Further observation revealed the fall mat folded up and leaning against the end of the bed and not on the floor, as outlined in the plan of care. On 12/2/15 at 8:00 AM, Nurse Aide F stated the resident has a lot of falls because he/she tries to get up on his/her own. Nurse Aide F further stated the resident has a personal alarm and a fall mat beside his/her bed. On 12/2/15 at 2:40 PM, Licensed Nurse B stated the resident has a personal alarm since admission and the fall mat was a new intervention after a fall. Licensed Nurse B further stated the staff frequently check on the resident. On 12/3/15 at 1:45 PM, Administrative Nurse A stated the staff frequently check the resident and the resident has a pressure pad alarm. Administrative Nurse A stated the nurse should update the plan of care with interventions after a fall. The 6/18/07 facility's Care Plan Policy stated the facility would provide proper care for residents to ensure timely and accurate documentation and information to the resident and their	F 280		

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F 280	Continued From page 42 representatives by using the resident assessment to develop, review and revise the resident's care plan. The policy further stated the care plan corrections and changes would be made to the resident's care plan by editing the care plan, as needed, between care plan meetings. The facility failed to review and revise the care plan with additional interventions, for Resident #32, who had multiple falls.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observations, record review and interview, the facility failed to meet professional standard of quality care for not following physician's orders for 1 of the 13 sampled residents. (#19) Findings included: - Resident #19's diagnoses from the Physician's Order Sheet, dated 10/6/15, included weight loss. The quarterly (MDS) Minimum Data Set assessment, dated 10/25/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 8, which indicated moderate cognitive impairment. The assessment revealed the resident had a weight loss of 5% or more in 30 days, or 10% or more in 180 days. The 10/14/15 care plan stated the resident has	F 281		

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many food intolerances/allergies, makes his/her own meal choices, and has a diet as tolerated.

Review of the medical record revealed on 8/27/15, a Doctor Communication Sheet was faxed to the physician stating the Dietitian recommended considering a multi-vitamin with mineral supplement, due to weight loss. The physician agreed with the recommendations. Further review of the medical record revealed the physician's order, for a multi-vitamin with minerals, was not initiated for the resident.

Review of the September/October/November (MAR) Medication Administration Record revealed no documentation of a multivitamin administered to the resident.

On 12/1/15 at 11:22 AM, observation revealed the resident seated in his/her wheelchair in the dining room, at a table set lower than standard height to meet his/her needs.

On 12/2/15 at 12:15 PM, observation revealed staff served the lunch in the dining room to the resident, who was seated in his/her wheelchair at a table. Further observation revealed staff served the resident a supplement containing Coke and ProMod (a physician ordered dietary supplement).

On 12/2/15 at 2:55 PM, Administrative Nurse A verified he/she could not find evidence the physician's order for multi-vitamin with mineral supplement was started, and verified the resident had not received the medication.

The facility's 7/27/15 Charting policy indicated when staff sent a communication sheet to the doctor and had been returned to the facility with

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F 281	Continued From page 44 orders, the communication sheet should be noted by a nurse, and orders taken off by the nurse. The facility failed to provide professional standard of care by not initiating the physician ordered multi-vitamin with minerals supplement for weight loss to Resident #19.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to provide the necessary services to maintain grooming and personal hygiene for 1 of the 3 residents reviewed for activities of daily living. (#32) Findings included: - Resident #32's admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, transfers, and toileting. The assessment further revealed the resident dependent upon 1 staff member for bathing. The 8/17/15 (CAA) Care Area Assessment for activities of daily living was not completed.	F 312		

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F 312	Continued From page 45 The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing and personal hygiene. The assessment further revealed bathing did not occur during the assessment period. The 11/19/15 care plan indicated the resident preferred showers and directed the staff to assist the resident with a shower 2 times a week. The September 2015 bathing record revealed the resident hospitalized from 9/1/15-9/18/15 and only received a shower 2 times from 9/18/15 - 9/30/15. The October and November 2015 bathing record indicated the resident received a total of 8 showers for both months. On 12/3/15 at 9:30 AM, observation revealed the resident lying in bed with his/her eyes closed. Further observation revealed the resident's hair and face appeared clean. On 12/3/15 at 9:51 AM, Nurse Aide E stated the staff offer the resident a bath daily but the resident often refuses. On 12/3/15 at 1:45 PM, Administrative Nurse A stated the resident should have had more baths or the staff should have documented correctly and verified the documentation of only 8 baths in 2 months. Administrative Nurse A further stated if the resident refused a bath he/she still expected the staff to bathe the resident 1 x week.	F 312		

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F 312	Continued From page 46 The 7/13/15 facility Bathing Policy stated the bath aide will make every attempt to provide baths to all residents during the bath aides scheduled hours of Monday through Friday 6:00 AM - 2:00 PM and the baths are documented in the facility's computer system. The policy further stated, if the resident refused, the refusal is documented and if the resident continues to refuse, the Social Service Designee would be notified for assistance. The facility failed to ensure Resident #32 received a shower or bed bath twice a week, to maintain grooming and personal hygiene needs.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents of which 3 were reviewed for accidents. Based on observation, record review and interview the facility failed to ensure that the residents' environment remains as free of accident hazards as possible for 1 of 3 residents who had falls. (#32) Findings included: - Resident #32's admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated	F 323		

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the resident had a (BIMS) Brief Interview for Mental Status score of 14. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident had unsteady balance, no functional upper or lower impairment, and no falls since admission.

The 8/17/15 (CAA) Care Area Assessment for activities of daily living was not completed.

The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident had unsteady balance, no functional upper or lower impairment, and had 2 or more falls since admission.

The 8/13/15 care plan stated the resident, a high risk for falls, had an unsteady gait, and used the call light when needing assistance. The care plan directed the staff to keep the bed in the lowest position to minimize injury should he/she fall out of bed. The updated 11/6/15 care plan directed staff to place a fall mat beside the resident's bed. The care plan lacked further intervention for staff after the resident had falls on 11/12/15, 11/18/15, 11/24/5, 11/28/15, and 12/3/15.

The 11/6/15 at 3:31 AM, nurse's note indicated the staff found the resident on his/her knees and elbows on the floor, a few feet from his/her bed. The note further indicated the resident stated he/she was trying to shut off his/her light. The note stated the staff assisted the resident to

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F 323	Continued From page 48	F 323		

his/her feet, and then assisted him/her to the bathroom. The note further stated the resident's legs gave out while being assisted back to bed and the staff used a wheelchair to get him/her back to bed.

The 11/12/15 at 6:45 PM, nurse's note stated the staff found the resident on the floor in front of his/her recliner on his/her alarm pad. The note stated the resident's alarm was not connected to the chair and the resident had no injury. The facility educated the staff to make sure the alarm was appropriately attached.

The 11/18/15 at 1:35 AM, nurse's note stated the staff found the resident with his/her head on the floor mat and his/her legs still in the bed. The note stated the resident had two nickel size abrasions to the top and front of his/her head.

The 11/18/15 fall risk assessment indicated the resident was a high risk for falls.

The 11/24/15 at 3:27 PM, nurse's note stated the staff found the resident standing beside his/her bed, as the resident slowly lowered him/herself to the floor onto his/her knees. The note stated the resident had no injury.

The 11/28/15 at 4:05 PM, nurse's note stated the resident leaned over the armrest of the recliner and his/her spouse could not get the resident back up into the recliner. The note stated the resident's spouse assisted the resident down the footrest of the recliner and onto the floor.

The 12/3/15 at 6:14 AM, nurse's note stated the staff found the resident lying on his/her right side on the floor mat beside the bed. The note stated the alarm was sounding and the resident was

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F 323	Continued From page 49 assisted back to bed. On 12/1/15 at 11:58 AM, observation revealed the resident lying in his/her bed with eyes closed. Further observation revealed the fall mat folded up and leaning against the end of the bed and not on the floor, as outlined in the plan of care. On 12/2/15 at 8:00 AM, Nurse Aide F stated the resident has a lot of falls because he/she tries to get up on his/her own. Nurse Aide F further stated the resident has a personal alarm and a fall mat beside his/her bed. On 12/2/15 at 2:40 PM, Licensed Nurse B stated the resident has a personal alarm since admission and the fall mat was a new intervention after a fall. Licensed Nurse B further stated the staff frequently check on the resident. On 12/3/15 at 1:45 PM, Administrative Nurse A stated the staff frequently check the resident and the resident has a pressure pad alarm. Administrative Nurse A stated the nurse should update the plan of care with interventions after a fall. The 7/12/13 facility's Fall Policy stated all residents are considered at risk for falls due to age, diagnoses, medications and changes in environment. The policy stated a plan of care shall be completed to include potential risks and the staff assess the resident for toileting needs, keep beds in low position, keep rooms free of clutter, assistive devices if needed, and utilization of bed and chair alarms for high risk residents. The facility failed to implement measures to prevent further falls for Resident #32, who had	F 323		

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F 323	Continued From page 50 multiple falls.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 28 residents. The sample included 13 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to adequately monitor bowel management for 1 of 5 residents reviewed for unnecessary medications. (#32) Findings included:	F 329		

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- Resident #32's medical record revealed the facility admitted the resident on 8/11/15.

The (POS) physician's order sheet, dated 9/18/15, revealed the resident had a diagnosis of constipation (bowel movements that are infrequent or hard to pass).

The admission (MDS) Minimum Data Set assessment, dated 8/17/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14. The assessment revealed the resident required limited assistance of 1 staff member for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident was always continent of bowel.

The quarterly MDS, dated 11/17/15, indicated the resident had long and short term memory problems with severely impaired cognition. The assessment revealed the resident required extensive assistance of 3 for bed mobility, transfers, toileting, dressing, and personal hygiene. The assessment further revealed the resident was occasionally incontinent of bowel.

The 8/13/15 care plan stated the resident did not have constipation and directed the staff to toilet the resident per the toileting schedule. The care plan lacked direction for the staff regarding bowel management.

The 8/11/15 physician standing orders directed the staff to administer the following:
(MOM) Milk of Magnesium, (a laxative for constipation) 30 (cc) cubic centimeters, by mouth, with breakfast, if no bowel movement for 3 days.
Dulcolax Suppository, (a laxative for constipation

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F 329	Continued From page 52 inserted into the rectum) rectally, once at bedtime, if the resident has not had a bowel movement for 4 days. The order further directed the staff to notify the physician if no bowel movement for 5 days. The October Bowel Movement Record revealed no documentation the resident had a bowel movement from 10/1/15 to 10/15/15 (15 consecutive days). The November Bowel movement Record revealed no documentation the resident had a bowel movement from 11/3/15 to 11/17/15 (15 consecutive days) and no bowel movement from 11/18/15 to 11/27/15 (10 consecutive days). The October and November (MAR) Medication Administration Record revealed the staff had not provided physician ordered interventions to the resident for the lack of bowel elimination, as outlined in the physician standing orders. On 12/2/15 at 4:37 PM, observation revealed the resident lying in bed on his/her right side, Nurse Aide G performed personal hygiene on the resident, replaced the disposable incontinent pad, put a pillow between his/her knees, and covered the resident. On 12/2/15 at 4:37 PM, Nurse Aide D stated staff chart bowel movements in the computer system. Nurse Aide D stated, if the resident doesn't have a bowel movement for 3 days, the staff notify the nurse. On 12/2/15 at 2:47 PM, Licensed Nurse B stated the computer system and staff tell him/her when a resident has not had a bowel movement after 3	F 329		

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F 329	Continued From page 53 days and the nurse initiates the standing orders. On 12/3/14 at 1:45 PM, Administrative Nurse A stated the staff document when a resident has a bowel movement and are to assess the resident if he/she had not had a bowel movement, then initiate standing orders. The 7/17/14 facility's Laxative and Bowel Movement Protocol stated the resident bowel movements are recorded on the facility computer system at shift change, the off duty shift report to the oncoming nurse any concerns regarding bowel movements. The charge nurses are responsible for looking at the activity of daily living flow sheet to ensure the resident has regular bowel movements. The policy stated when a resident that has not had a bowel movement for 3 days, the nurse will administer MOM, 30 cc's, at breakfast. If no bowel movement after 4 days, the nurse will administer a Dulcolax suppository, rectally, at bedtime. Should the resident still not have a bowel movement after 5 days, the nurse notifies the physician. The facility failed to adequately monitor the bowel management program, complete appropriate physical assessment, and follow the physician's standing orders for bowel management for Resident #32.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This Requirement is not met as evidenced by:
The facility had a census 53 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to prepare, distribute and serve food under sanitary conditions in 1 of 1 dining rooms.

Findings included:

- On 12/2/15 at 11:50 AM, observation revealed the following food temperatures, taken from the lunch meal: pureed lasagna 135 degrees Fahrenheit and the pureed baked potatoes 122 degrees Fahrenheit.

Review of the food temperature logs, for the lunch meal on 12/2/15, revealed no documentation of the pureed foods.

Further review of the monthly temperature logs revealed during the month of October 2015, on 10/8/15 and 10/9/15 temperatures were not recorded for the breakfast meal. On 10/4/15, 10/8/15, 10/9/15, 10/16/15, and 10/23/15 temperatures were not recorded for the noon/lunch meal. On 10/1/15, 10/2/15, 10/5/15, 10/9/15, 10/11/15, 10/14/15, 10/21/15, and 10/22/15 temperatures were not recorded for the supper meal.

Further review of the monthly temperature logs revealed during the month of November 2015, on 11/20/15 and 11/22/15 temperatures were not recorded for the breakfast meal and lunch/noon meal. On 11/2/15, 11/8/15, 11/14/15, 11/15/15,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 3RD ST PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 55 11/16/15, 11/21/15, 11/22/15, 11/23/15, 11/24/15, 11/29/15, and 11/3015 temperatures were not recorded for the supper meal. On 12/2/15 at 4:00 PM, Dietary Staff L confirmed he/she was aware of the lack of temperatures being recorded, on the monthly temperature logs, and stated the dietary department had new staff. The facility food temperatures policy, dated 3/22/13, stated all temperatures of food items will be taken and properly recorded for each meal. The food temperature procedure, dated 3/22/13, stated all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit. Temperatures should be taken periodically to ensure hot foods stay above 135 degrees Fahrenheit, and cold foods stay below 41 degrees Fahrenheit during the portioning, transporting, and serving process until received by the resident. The facility failed to prepare, distribute and serve food under sanitary conditions for the 28 residents who receive their meals from the facility kitchen.	F 371		